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CMS Issues Three NCDs Preventing Medicare Payment for 'Never Events'

Three recently released national coverage determinations aim to eliminate specific preventable surgical errors and payments for services relating to them. The errors these NCDs address are included in the National Quality Forum's (NQF) list of 28 "serious reportable events," which are both serious and preventable. These events are commonly known as "never events."

The surgical "never events" include:

- Performing the wrong surgical or other invasive procedure (i.e., other than the intended procedure) on a patient
- Performing the wrong surgical or other invasive procedure on the wrong body part, e.g., left side versus right side or at the wrong vertebral level
- Performing the wrong surgical or other invasive procedures on the wrong patient, i.e., procedure intended for a different patient or inconsistent with the procedure documented on the informed surgical consent for that patient

According to the coverage determinations, when a provider erroneously performs a surgical or other invasive procedure to treat a particular medical condition, such as on the wrong patient or body part, Medicare will not cover that particular procedure because it is not reasonable and necessary. For Medicare to cover a service, it must be reasonable and necessary treatment for the patient's medical condition.

CMS defines "surgical and other invasive procedures" as those in which skin, mucous membranes, and connective tissue are incised or in which an instrument is introduced through a natural body orifice. This includes all procedures classified in the surgery section of the CPT book. Invasive procedures include biopsies, lesion excisions, organ transplantation, percutaneous transluminal angioplasty, and cardiac catheterization as well as placement of catheters through a needle or trocar. Minor procedures such as drawing blood and otoscopy are not included in the definition.

These coverage determinations continue the implementation of the Deficit Reduction Act (DRA) of 2005, section 5001(c), in which CMS has begun to address some of the NQF never events, such as hospital-acquired conditions (HACs). Medicare will no longer pay a hospital at a higher rate for an inpatient hospital stay for one of the HACs acquired during the hospital stay effective for discharges on or after Oct. 1, 2008. The HAC conditions are from the 28 never events listed by the NQF, including blood transfusion incompatibility, air embolism, foreign objects retained after surgery, stage III & IV pressure ulcers, injuries related to falls, and other events such as electric shock and burns. CMS recently added manifestations of poor glycemic control, such as hypoglycemic coma. The HAC payment provisions pertain only to hospitals for inpatient stays; however, these NCDs affect payment to hospitals, physicians, and any other health care provider or supplier involved in the erroneous surgeries.

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